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CASE WORK ACTIVITY IN THE TREATMENT OF FIVE CASES ON THE NEUROPSYCHIATRIC SERVICE OF THE VETERANS ADMINISTRATION HOSPITAL, WEST ROXBURY

A THESIS

Submitted by

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Chapter I

Introduction

> Psychiatric social work stands today as . . . [a] specialized area [of social work], with a developing body of knowledge and skill that is forming the basis of specialized training. It represents social work practiced in connection with psychiatry and mental hygiene in organizations that have for their primary purpose the study, treatment, and prevention of mental and nervous disorders.[1]

The physician and the worker share this same purpose, however their focus is different. The doctor brings a knowledge of medicine and psychiatry enabling him to deal with intrapsychic conflicts, while the worker brings a knowledge of social case work and community resources which enables her to deal with situational factors. At times an interchange in the focus of treatment occurs with the physician becoming aware of deterrent social factors and the worker becoming aware of, and under supervision, handling intrapsychic conflicts.

The role of the case worker in any problem is usually an ever-changing one. The physician is responsible for the planning and management of each patient; the case worker's function comes within that framework. Her role may be limited at first, but then expand to embrace many aspects of treatment; it may on the other hand, become increasingly limited as more knowledge of the patient's disease is obtained.

To help carry out her function, the case worker has a wide variety of treatment techniques. Chief among them is the psychological approach aimed at gaining the patient's confidence to enable him to

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[1]Lois Meredith French, Psychiatric Social Work, p. 3

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discuss his problems and his thoughts. This approach is carried on through a manifest interest by the worker in the problems he presents, by helping him feel understood and accepted, by relieving guilt feelings, by reenforcing ego-strengths and by giving approval and respect to the patient's activity whenever possible. Through the use of these techniques, the worker is enabled with the guidance of the physician to clarify the patient's unconscious feelings and motivations and give insight into his psychopathology. The exact techniques used and mechanisms of change will always depend on the individual case.

In addition the worker concerns herself with his social setting. Knowledge of the patient's relationships in his social milieu helps in understanding and treating him. Knowledge of his family and his environment adds understanding to his disease. Knowledge of community resources available often alleviates certain environmental strains.

Therefore in psychiatric social work, the case worker brings case work principles, casework skills, and a knowledge of the community and its resources into the treatment situation which she shares with the psychiatrist.

It is the purpose of this thesis to study these techniques, their wide variety, together with some of the results and limitations. Five cases will be presented in summary form and in each, emphasis will be placed on the case work activity contained rather than on the patient's disease. A discussion of the significant case work activity will follow each presentation. These cases have been taken from the author's clinical experience from October, 1948 to February, 1949 on the Neuropsychiatric Service of the Veterans Administration Hospital, West

Roxbury, Massachusetts. All data presented were taken from hospital records, personal notes and summaries of conferences between the psychiatrist in charge of each case and the Social Service Department. The presentations are designed to make apparent these techniques rather than to represent complete case histories.

Chapter II

FUNCTION OF THE CASE WORKER ON THE NEUROPSYCHIATRIC SERVICE OF THE VETERANS ADMINISTRATION HOSPITAL, WEST ROXBURY

The Neuropsychiatric Service of the Veterans Administration Hospital is but one of the many hospital services available for the treatment and care of the veteran with neuropsychiatric disease. Also contributing are other services of Physical Medicine and Rehabilitation, (this includes Physical and Occupational Therapy), Vocational Rehabilitation and Education, and Clinical Psychology.

The medical staff of the Neuropsychiatric Service is composed of a chief Neuropsychiatrist, and several assistant psychiatrists, along with consultants who visit weekly. In addition, at the time of this thesis, there was a social service unti composed of the Acting Chief of Social Service and two case workers who functioned solely on the Neuropsychiatric Service.

The setting at West Roxbury provided an opportunity for this case worker to have a broad experience because of the physician's progressive concept of the function of the case worker. Stimulated by the physicians on the Neuropsychiatric Service who were always available for consultations and who unstintingly shared their knowledge, the worker was able to take advantage of case work in a wide variety of situations. With the feeling of confidence and security that such a background brings, the case worker was able to function most effectively.

All of the referrals to social service came in the course of a weekly seminar held among the physicians, the Chief of Social Service, and two case workers. In addition to being a source of referrals, these seminars provided an opportunity to integrate psychiatry with social work, and thus for social service to share in the treatment and management of the patient's hospital course. These seminars gave the worker not only a better understanding of the patient, but also an enriched appreciation of psychiatry and a greater understanding of case work.

Case work activity was carried on under the guidance of the referring physician on whom responsibility for the patient's hospital course was vested, and the Chief of Social Service; close collaboration with other hospital services interested in the patient's treatment was also maintained.

The steps shared by the physician and the worker involved a study of each patient, an analysis of the data and the diagnosis, and a formulation of a plan of treatment. In each situation, the physician and the worker decided what the patient's conflicts were and how they could be treated most effectively.

In each case the physician and the worker were interested in the same treatment goal, that is, to improve the patient's mental and physical health so that he could return to the community. The focus of the psychiatrist was with the patient's inner tensions, whereas the social worker was concerned chiefly with social problems relating to the patient's illness. Although the worker may as a result of her work have

brought about modified personality changes in the individual, her main concern was with reality difficulties.

The function of the case worker on the Neuropsychiatric Service derives its authority from the physician in charge of the patient. The functions and activities of the case worker are almost as diffuse in nature as the number of cases of psychiatric disorders. The exact function and activity performed depends in reality on those which are most applicable to the individual case. It is therefore impossible to present all of these varieties in this paper. However, the writer tried to summarize some of the chief characteristics and broader categories of case work functions and activities, in the outline below.

THE FUNCTIONS AND ACTIVITIES OF THE PSYCHIATRIC CASE WORKER

A. With regard to the patient, himself: the function here involves an understanding of the patient, the meaning of his illness, his attitudes towards his life situation, his willingness and ability to effect a change, and his objectives in life.

1. Related activities of the case worker:

a. establishing a positive relationship with the patient gained through a warm, accepting, non-judgemental approach

b. identifying with the patient

c. giving "encouragement...[so that] he will eventually attain the goal of his usual normal situation in life"[1]

d. increasing ability of the patient to express himself and gain relief from pent-up feelings

e. re-enforcing ego strengths

f. giving interpretation

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[1]LeRoy M.A. Maeder, M.D., "Diagnostic Criteria--The Concept of Normal and Abnormal," The Family, 22:6, October, 1941, p. 171.

g. relieving guilt feelings

h. helping carry out recommendations of the physician

i. giving emotional support and approval

j. ascertaining the patient's attitudes, aims, ambitions, his general health, his progress in school and job, his social integration in family, business and social groups.

k. assisting the psychiatrist in deeper psychotherapeutic problems.

B. With Regard to the patient's environment: the function here deals with becoming "acquainted with the major events and relevant persons in his life,"[2] and their relationship to his difficulty, manipulating his environment to modify or alleviate strains.

1. Related Activities of the case worker:

a. establishing a positive relationship with members of the patient's family when beneficial to the patient

b. evaluating strengths and weaknesses in the patient's environment

(1) developing an awareness of the extent to which the weaknesses are debilitating.

c. interpreting the physician's recommendations to the patient's family

d. offering help with material needs through a knowledge of community resources

e. evaluating the patient's satisfactions in his job and recreational activities

C. With Regard to work with both the patient and his environment: the function here involves integrating work with the patient to his life situation.

1. Preparing for the best kind of an environment for discharge planning both physically and psychologically which involves:

a. preparing the patient and his family for his return to the community.

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[2]Edmund F. Walker, M.D., "The Effectiveness of the Psychiatric Social Worker in the Treatment Situation," Mental Hygiene, 31:4, October, 1947, p. 592.

b. giving advice as to the practical measures to solve surface family problems

c. giving information regarding housing, budgeting, methods of living, etc.

d. serving as liaison between the patient and his community

(1) stimulating the interest of those in his community who could help him

D. With Regard to work with the Psychiatrist: the function here involves close collaboration with the physician through frequent conferences to evaluate treatment objectives; gaining information for the use of the physician in diagnosis, treatment and prognosis; serving to interpret the physician's recommendations to the patient and his family which involves:

1. seeking frequent conferences with the physician

2. observing the patient who "shows an excessive emotional reaction to some relatively simple difficulty, or who blocks continually in taking certain steps, or is extremely dependent, or manifests other signs of possible emotional problems, the worker will be able to share her observation with the physician . . . "[3]

3. maintaining contact with the patient's family when feasible

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In all case work there is a broad interplay of case work functions and case work activities. Each case can include a great many combinations of activities along with a function which can develop or delimit as case work progress continues. It would be impossible to find any clear-cut combination of functions and activities in any one case. The need for a warm, acceting relationship which gives the patient courage and confidence to face the reality of his life situation, can be

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[3]Harriett M. Bartlett, "Emotional Elements in Illness: Responsibilities of the Medical Social Worker," The Family, 21:2, April, 1940, p. 41.

seen, however, in every case. When environmental strains are present, alleviating them is often given precedence to remedy a difficult situation and to stimulate the patient-worker relationship.

This framework of treatment came under the jurisdiction of the physician to whose knowledge the worker added her case work skills and knowledge of community resources for the treatment of the veteran on the Neuropsychiatric Service.

Chapter III

Presentation of Cases

Patient A; illustrating clarification of an economic problem and direct treatment of emotional problems.

The patient was a thirty year old, single, veteran of World War II, admitted because of nervousness for the past two and one-half years, with increasing severity for one week.

The patient had always been well until just prior to his discharge from the Army when he noted the onset of nervousness. He attributed this to his recent combat experience and to his concern over his psychotic father who was becoming increasingly difficult to manage. On returning from Service, the patient together with John, a bother, committed their father to a mental institution, from which he escaped on several occasions. In the most recent escape, the father threatened Denise, the youngest child, with a knife. During lucid intervals, the father accused the patient of "railroading" him into the hospital. These episodes and the fear of similar recurrences increased the patient's nervousness until he could no longer work.

The patient was one of six children, of whom a younger sister, Denise, and the patient were living at home with the mother. An older brother and sister were married and living in their own homes. Two younger brothers, John and Angelo, were in Military Service.

The physical examination was negative and the admission diagnosis was psychoneurosis, chronic and severe.

The patient was kept sedated for his first ten hospital days and little attempt was made at specific therapy. On the thirteenth hospital day he complained of dizzy, shaky spells, nervousness, irritability and was weeping and sobbing uncontrollably. While on a weekend pass, he had visited his father, was unable to overcome the emotional shock and fear. He was symptomatically relieved by the psychiatrist's reassurance that he would not become like his father.

For the next four days, the patient ate little, cried a great deal and expressed concern over finances at home, whereupon he was referred to social service for investigation of and possible remedy for this problem. Secondarily, it was hoped that a positive worker-patient relationship could be established which would encourage the patient to talk about his problems thus providing more knowledge on which treatment could be based.

The initial interview with the worker began easily despite his sobbing, by a discussion of the patient's and the worker's common geographical background. The subject was then directed with facility to the patient and his family which were discussed in an unrepressed manner between sobs.

The patient left school at fifteen because he "didn't like the teacher and money was needed at home". He learned to be a baker and as such was earning $54.00 a week up to his hospitalization, and gave his entire pay to his mother, an arrangement which seemed natural to him. In return, she cooked his favorite meals and bought his clothes. For recreation, he went to a veterans post where he met his friends, had a few glasses of beer and occasionally danced. This was not often, however, because of a lack of money.

His psychotic father had been committed to a state hospital (mental) two years previously and since then, had escaped four times. On the last occasion, he attempted to commit suicide. While relating this, the patient's sobs became more pronounced.

Of the financial problem, he said that John was sending home a monthly allotment which was insufficient since he, himself, was not now working. The family also owned some property which could be made to yield an income. After close questioning, there did not seem to be any great or urgent financial problem at home.

The interview terminated with reassurance given regarding possible methods for preventing further escapes by the father.

Since a positive patient-worker relationship had been established, it was recommended by the physician in conference, that it be maintained by regular interviews. Through this relationship, it was hoped that the patient would verbalize his fears and perhaps by this technique gain some insight, and make his fears of his father seem less terrible. A sodium amytal interview revealed the patient's deep attachment for his mother.

In the next two interviews on the twenty-fifth and twenty-sixth hospital days, the patient was quite cheerful and not sobbing. He easily resumed a discussion of his father and his relationship with his mother, especially when informed that the physicians caring for his father promised stringent measures to prevent further escapes. He discussed his mother's dependence on him for visits to his father. As he talked, he gained clarity regarding the affects of these visits on himself and with the worker's encouragement, decided against further visits.

In addition to repeating material already discussed, the patient described his attitudes towards authoritarian people, namely his employers and his officers in Service. In general he felt they wanted to take advantage of him and therefore he was forced to

constantly battle them to protect his rights. One exception to this attitude was a Mr. Smith who taught the patient his trade of baking, and took him fishing and hunting on occasion.

Because the patient's symptoms had not returned and he seemed to be improving, he was allowed to go home for the weekend.

In conference with the physician, it was agreed that the patient's relationship with Mr. Smith should be encouraged. He represented the good father who understood and took care of him and who could help and protect him. In contrast the worker was the big sister towards whom he must maintain a level of performance. He did not want her to see him sobbing, therefore she acted as an incentive to him to expend every effort in benefitting from treatment. Both Mr. Smith and the worker represented good possibilities for discharge planning.

In interviews on the forty-sixth and forty-seventh hospital days, the patient manifested a return of some of his symptoms. He was shaky and dizzy and because he did not "feel like talking", the interviews were brief.

On the fifty-third hospital day, the interview again disclosed his great guilt in having committed his father and he reiterated his justification. This gave the worker an opportunity to reassure him on the wisdom and necessity of his actions. The patient accepted the reassurance readily and related that Angelo was home, "was behaving", and was taking care of their mother. The worker shared his joy as well as his enthusiasm for his recently planted garden.

A few days later, the worker interviewed the patient's mother. She was an anxious, middle-aged woman who had been having menopausal symptoms for the past five years. Her husband continued to cause Denise and herself to be continually upset. Since her father's last escape, Denise had been having nightmares. The mother was aware that her husband was now more carefully supervised, but she was unable to accept this and readjust her thinking and acting accordingly. She was still very careful to keep the windows and doors locked.

After his mother's departure, the patient came to the Social Service Office. He knowingly resumed one of the topics of his mother's discussion, namely, her difficulty in mustering sufficient food when he came home. He was particularly concerned over his approaching Thanksgiving Day at home and readily accepted the worker's offer of provisions for Thanksgiving.

In the interview held on the seventy-second hospital day, the patient manifested a return of his symptoms and a new symptom.

His body had started "to vibrate"; it felt as though he had his hands on a revolving machine. He could not understand why he felt this way. He hadn't been thinking of his father and he wasn't worried about finances. He seemed prepossessed with his symptoms.

In conference, the physician described the patient's vibration as a somatic delusion. The psychiatrist felt that the patient was developing a schizophrenic psychosis. If he resumed sobbing, it would be necessary to refer him for more intensive treatment. The doctor did not think that the mother was capable of much insight into the patient's problems. She represented an old cultural pattern which would be difficult to change. The patient was a substitute for her husband, a role he accepted.

In the next three interviews occurring on the seventy-fifth, seventy-sixth, and seventy-seventh hospital days, the patient discussed his feeling of vibrating which he associated with military service; every time he had to face inspection, he got shaky. He looked on the hospital as the place where he would become a new man and he constantly spoke of not wanting to leave until he was sure he would not return. On the eightieth hospital day, the patient was discharged as having attained maximum hospital benefit. He went home to rest prior to seeking employment. If he was unable to secure employment, he was assured that the vocational advisor at the hospital would help him.

A month later, the patient visited the hospital with some cakes for the worker and the physician. He was living at home and had a job as a cake decorator which he felt he could handle. He seemed to be adjusting to life in the community.

By the method of identification, good rapport with the patient was early and easily established. A general discussion of their common geographical background allowed the patient the opportunity of converting at leisure the discussion with the worker to the subject of the traumatic events in his life situation contributing to his breakdown.

Having determined that no acute financial problem existed, the worker entered into direct treatment with the patient and maintained this throughout his period of hospitalization. The worker's approach was one of warmth and acceptance to help the patient verbalize on his emotions. As he did so, the original events precipitating his

emotional discharge became weak thus seeming less alarming to him; he benefited noticeably by this simple measure.

Through a positive relationship thus established in a relaxed atmosphere, the patient was given reassurance, approval and emotional support. Whenever possible, the worker relieved his guilt and showed him that she respected his activity. The worker manifested an active interest in whatever he cared to bring into the interviews ranging from his former employers t his situation at home or to his garden, and always treated it with a very understanding attitude. By encouragement and by providing somewhat the stimulus for action, the workerwas able to contribute to his treatment and rehabilitation. By carefully ascertaining the home situation, with the aid of an interview with the patient's mother, the therapeutic possibilities and prognosis at home after discharge were clarified.

Patient B: illustrating environmental manipulation by the case worker through the patient's wife, resulting in relief of tension and anxiety in the patient; illustrating case work treatment of the patient himself by verbalization of his frustrations and by discharge planning.

The patient was a twenty-four year old, married veteran of World War II admitted because of four spells of amnesia, lasting from twelve to twenty-four hours. The first episode occurred one year ago during a period of great nervous strain resulting from concern over his wife's health, their lack of finances and his inability to find suitable employment. Between spells, he was symptom-free and following each attack, he could not recall any events of the amnesia period. The last episode occurred one month before this admission.

Three years before, the patient married an eighteen year old girl whom he had met while in Service. Although they had been

settled in the East for two years, they were besieged by the patient's mother to visit her in the West, since she wrote that she was dying of heart trouble. The patient gave up his job, sold their furniture and borrowed money to make the trip, only to find his mother quite well. Being without further funds they were forced to settle in the West and returned East only three weeks ago. At that time the patient's wife was threatened with another miscarriage, her fifth since their marriage. They had returned to the East so that the wife could be near her mother during the rest of her pregnancy and the patient could be hospitalized. The patient did not express any anger towards his mother for having contributed to his difficulties.

The physical examination was negative. The physician's initial impression was that the patient was suffering from an hysterical fugue.

Three days later the physician referred the patient's wife to social service to discover the relationship, if any, between the patient's marital life and his attacks of amnesia.

The patient's wife, a pretty girl who appeared five months pregnant, readily expressed her fears that she would have another miscarriage because she was unable to purchase medicines advised by the doctor in the West. Since her husband's admission, she had been without funds, although she had made several attempts to obtain some. She did not feel free to ask her parents for any more money since they were already providing her food and shelter. Since they treated her as an intruder, she considered herself fortunate to be allowed to live with them.

A discussion ensued resulting in the wife's ready acceptance of a referral for pre-natal care at a maternity hospital where she could make satisfactory financial arrangements.

During the rest of the interview, the wife told of her husband's childhood, her own, and discussed some of the highlights of their marriage.

As a child, she had had many luxuries, but little love. Her parents had many outside interests, and she saw little of them. Both had been married previously; her father was divorced by his first wife, while her mother's first husband had died. She was the only child of this marriage. She stated that even as a child she remembers feeling rejected. When she married, she looked for the love and affection she had missed. Shortly after marriage, however, she realized that her husband was "only a boy". He had joined the Navy from high school, married her upon discharge, and now having a pregnant wife was giving him responsibilities for which he was not prepared. However, she also realized that

she had given her husband little thought. Like herself, he was an only child. His mother was alcoholic, his father, a "nervous" man who was constantly away on business trips. She discussed her mother-in-law with a great deal of hatred and cried as she recalled the way she disrupted their lives.

As the interview terminated, the wife expressed gratitude for the worker's interest, and at her request, was given an appointment to return in a few days.

In the second interview, the wife resumed discussion of early rejection by her parents and of her disappointed expectations in marriage. In addition she related the difficulties she and her husband encountered in living with her parents, the possibilities of an apartment of their own, the attitudes they had towards children and her recent visit with the husband.

As a newly married couple their many problems had forced them to live intermittently and unharmoniously with her parents, as frankly unwanted guests. Recently her father offered them an apartment to be available shortly. This possibility had given her the great hope that they would soon have a home of their own.

She wished to have a child because her husband loved children and wanted one. She wanted a large family for his ake. She was constantly concerned, however, lest the child be defective or abnormal and disappoint her husband. She had no very great desire to have children for her own sake.

The worker encouraged her to talk about these fears and reassured her that the possibility of a defective child was remote because she was about to have the best maternity care available.

Before this interview terminated, the wife reviewed her recent visit with her husband. She seemed pleased to relate that she spent most of the time listening to him and then told him about her talks with her worker.

In conference, the physician analyzed the positive influence that case work with the patient's wife had on relieving his symptoms. The patient had adjusted well to the ward, showed little evidance of anxiety, and was completing tests with the vocational advisor. He was now ready for a referral to social service for discharge planning.

In the two interviews with the patient, the worker encouraged him to talk about his plans following discharge. A discussion of these plans led to his recounting his many frustrations, and thence to his feelings about the baby.

He had decided to take a job with a former employer and to return to the hospital later for further discussions with the vocational advisor. With feeling, he told of the plans he had when he graduated from high school, and the reasons for his inability to carry out those plans. He had enlisted in the Navy to become a hospital apprentice, but was assigned as an elctrician's helper instead. He had planned to study pharmacy on discharge, but his wife's pregnancy interfered. He now felt that further education was impossible because they had so many obligations. He expressed relief that his wife was getting medical care and at a minimal rate. When they were home together, he was often afraid to leave her. Now he felt free to accept employment, knowing she was under competent care. He hoped that this baby would be born; rearing a child would give them a goal.

A month after his discharge, the patient had a job with opportunities for advancement and his wife was attending the pre-natal clinic regularly where a special interest was being taken in her medical problem.

The referral process developed from a simple request that the worker discover any relationship existing between the patient's symptoms and his marital life through an interview with his wife. The result of this interview was an assumption by the worker that the wife's environmenttal difficulties contributed to the patient's symptoms; thus, plans were laid to alleviate those problems. From that point, the referral process expanded to include the patient himself, and his discharge plans.

At the outset, the wife regarded the worker's activity only as providing funds to obtain medicine prescribed by a doctor in another state. However, through the worker she was able to see the wisdom of accepting immediate medical care. The result was a satisfactory referral to a maternity hospital. The tangible assistance thus offered and accepted became the basis for a friendly client-worker relationship of confidence and trust and gratitude.

As a result of this relationship, the patient's wife was able to express the rejections she felt as a child with her resultant expectations in marriage. As she verbalized on both her childhood and her husband's, she became aware of a relationship between the two, seeing the rejection they both had suffered. She thus saw herself as expecting too much of her husband. With the worker's support, she was able to adjust her attitude towards him, becoming more sympathetic towards him and his frustrations and taking a more active interest in his welfare and deemphasizing her own.

Through this accepted and understanding relationship, the wife was enabled to express her fears regarding this pregnancy. As she abreacted, the emotional strength of these fears became weak and the worker was able to reassure her regarding the probability of her giving birth to a healthy child.

The worker also offered the wife the gratification of discharging the hostility she felt towards her mother-in-law and her parents in an atmosphere of sympathy and tolerance. The worker offered herself as the one towards whom the wife could direct her feelings of anxiety and frustration instead of towards her husband who at that time was psychologically unprepared to accept them.

The referral process which developed to include the patient, himself, provided an opportunity for him to verbalize and gain a perspective of his life after discharge. He, too, expressed his frustrations. He was encouraged to face the future realistically instead of dwelling on his frustrated ambitions. He expressed his appreciation with the progress attained in the settlement of his wife's medical problem and

this appreciation was the basis for the immediate establishment of a positive worker-patient relationship.

On this case, one can conclude that alleviation of his wife's anxieties and some of her problems symptomatically relieved her husband's.

Patient C: illustrating exploration of a financial problem; the establishment of rapport to gain more history and social information in a deep-seated neurosis.

The patient was a thirty-nine year old, divorced, veteran of World War II admitted complaining chiefly of episodes of depression for two and one-half years. He also complained of restlessness, irritability, insomnia, anorexia and inability to work. One month before admission, he attempted suicide and had been kept under observation in a state hospital for several days. This admission was precipitated by another period of depression.

The patient claimed his first depressive episode occurred during his senior year in college, 17 years ago. When his girl friend married another man, he became depressed and left school. Ten years ago he married and had a son. Five years ago his wife separated from him because he was drinking, whereupon he enlisted in the Army. After discharge, he and his wife were reconciled and lived together for two years. He again became depressed and drank, whereupon she divorced him. Following this, he made his one attempt at suicide.

His physical examination was negative and he was admitted with a diagnosis of depressive reaction.

During the first two weeks in the hospital, the patient showed much interest in physical-therapy and occupational-therapy. On his twentieth hospital day, the physician referred the patient to social service to investigate the need of financial help for his son and also to gain more knowledge of the patient for purposes of diagnosis and treatment. He was to be encouraged to discuss his life situation, but excluding his depressive episodes because of the potential danger of suicide.

In the first interview, while nervously toying with the ashtray on the desk, the patient verbalized at length on his relationships with his wife and son, some of his war experiences, his job preferences, and his desire for "intellectual things". Each topic of discussion lead ultimately to the recounting of a different depressive episode.

When the worker inquired into his son's financial needs, she learned that he wanted money to buy gifts for his son who was being supported adequately by his wife, an industrial nurse.

He talked about her with mixed feelings. He felt that sometimes she was sympathetic with his difficulties, but most of the time was not. When he returned from service, he wanted "to make a man out of his boy" and take him from the grandmother's influence. To this his wife agreed, and yet after he established a home, she refused to entertain her friends there, lest he come home drunk. As a result, he got drunk and she separated from him. She defended him when verbally attacked by in-laws, yet was indifferent to his feelings of depression. His wife did not get along with her sister who informed him of his wife's unfaithfulness while he was in service. Although he was"no model", this made him depressed. After discharge from the service, at her insistence, he took a job as an attendant at a school for retarded children. This precipitated a depression and this admission according to the patient. His wife had long ago suggested that he go to a neuropsychiatric hospital and he felt that if he had, perhaps she would not have divorced him. It was in such conflicting terms that he spoke of his wife and their marriage.

With the worker's encouragement, he discussed his recreational interests. He liked intellectual books and people. Thelife of Edgar Allen Poeappealed to him because he identified himself with that poet who after losing his fiancee, went steadily downhill. He never associated with intellectual people because he did not feel on their level. Instead he went with a "low group" and "hung around" bars.

The patient enjoyed two kinds of work, physical-therapy and mechanical work. His college training in the former occupation was interrupted, when he left school. He expressed a desire to return to college and make-up his credits.

With a great deal of feeling, he discussed what his son meant to him. He wanted to become an officer while in service for his son's sake but could not because of a court record. The fear of stigmatizing his son had prevented his suicide several times before.

The interview terminated with the patient expressing sensitivity at being called "Pop" in the army because of his white hair.

In the next interview, the patient spoke of his early relationships. His father, now dead, was strict and never encouraged him to act independently. When his father reprimanded him, with justification, his mother consoled him. As a result, he "never faced things". Without affect, he said that perhaps much of his trouble was due to his mother, at least so his wife told him. In discussing his brother, he said that although he was a business school graduate, he had been drinking to excess and was reduced to the work of a laborer. With the financial help of an older woman, he was able to attend college, but did not graduate because of insuffieient credits. He contemplated making up those credits and taking up further study in physical-therapy or becoming a salesman.

Until he went to college, he had had no relationships with women other than his mother. With the encouragement of fellow-students, he dated girls and had "good clean fun". He helped his brother, who was also shy in this respect.

In the first conference with the physician, a discussion of the kind and depth of the patient's maladjustments led to a delimitation in treatment goals. As the patient would be discharged soon, the physician suggested that the case work interviews continue for any help with discharge planning that the patient might wish.

When again seen, the patient was lying in bed. He said that he had a headache and implied by his manner that he did not wish to see the worker. A few minutes before, he had visited The Social Service Office and was told that the worker was unavailable. His reaction to this "rejection" was to withdraw. The worker conjectured that he had given her the role of an accepting mother. He was repeating a behavior pattern by sulking and refusing to talk.

In the second conference, the physician and the worker evaluated treatment objectives. With the increased understanding of the patient, there came increased limitations in treatment goals.

The results of the Rorschach and the Thematic Apperception Tests which corroborated the findings of the physician and the case worker were discussed. They described a man with a hyperactive, punitive super-ego which forced him to strive despite a wish for a passive existance and prevented him from expressing aggression. He felt he had potentialities when in reality his ambition for achievement far exceeded his ability. He considered his mother good and ethical; any disappointments she caused, were done for his good. On the heterosexual level, he felt inadequate. He blamed liquor for his troubles, although he knew they went deeper. Emotional rapport was easily established, although at times it was apt to be shallow and quickly disrupted.

One note of optimism, however, was the patient's interest in a referral for vocational guidance with the aim of eventual physical therapy work.

The final interview concerned the patient's discharge plans. He discussed a conference with the vocational advisor which led to a decision to resume his old job although he clung to the plan of eventually returning to college.

When he expressed the desire to meet cultured people, the worker suggested clubs and activities with which he might become identified.

The patient was discharged with a diagnosis of psychoneurosis, chronic, severe.

Activity with this patient was chiefly concerned with gaining knowledge through a positive relationship for the physician to utilize in treatment. In accomplishing this function, the worker tried to give the patient emotional support and a feeling of being understood and accepted. At the initial social service interview, he readily accepted that his problem was not financial through his own verbalizations. He led the discussions of his intrapsychic relationships into the areas of his severe personality conflicts. He was encouraged to talk about non-threatening subjects like his recreational interests and his future employment plans. When he introduced the plan of returning to work instead of to school, he was supported in this activity. Whenever possible the worker re-enforced the patient's ego structure, helping him to plan realistically for his future. It was hoped that a successful relationship with a woman on a professional level would lead to further success in the patient's social life, however, the probability of this was not very great. The limitations of case work activity in such a severe neurosis is part of the generally poor prognosis of such personality maladjustments.

Patient D: illustrating environmental manipulation; the role of community agencies, and indirect treatment.

The patient was a twenty-six year old married veteran of World War II, admitted because of nervousness. His nervousness began during air raids and was then described as "electricity going through my body". Since then he had been nervous, afraid to sleep, "Scared inside," depressed, and had feelings that people were staring at him. For the past six monhs, he had had severe intermittent headaches which had become constant in the two weeks prior to this admission, forcing him to give up his job as a mill hand.

The patient was the fourth of ten children. He gave up school in the eighth grade because English was too difficult for him. Upon leaving school, he joined the Civilian Conservation Corps; then worked for the Works Progress Administration. He spent three and one-half years in the Army, and was in many air raids, but had incurred no injuries.

His physical examination was essentially negative. The psychiatrist's initial impression was a severe anxiety state, with a question of early schizophrenia.

On the second hospital day, the physician referred the patient to social service for evaluation of his financial problems, since situational factors seemed to be aggravating his present symptoms. In addition, the doctor was interested in knowing the extent to which the patient's behavior had been abnormal at home.

In the first two interviews, the patient who was tense at the outset, eagerly discussed his life situation prior to hospitalization. Most prominently was the patient's concern for his family because he did not know how they weremanaging financially. In addition he had entered the hospital unexpectedly leaving at home his wife and his three children, all of whom were sick.

In the first interview, at the worker's suggestion, the patient telephoned his home and verified his fears concerning the home situation. With the worker's assurance that assistance could be obtained, he relaxed and continued to verbalize.

This hospitalization was a culmination of several disturbing events. After the birth of his youngest child two months previously, his wife required further hospitalization for which he was financially unprepared. A month later, his elder son had a convulsion. His wife and son were both in need of further hospitalization, his wife for a vein ligation, and his son for a tonsillectomy. Finally, a week before this admission, he, himself, lost his job.

Since discharge from Service, he had had continuous employment as

a warehouseman until several months ago when the company closed. He then took a job in a mill. In the first interview he gave lack of work as the reason for losing the mill job; in the second interview he was able to say he gave up the job after a dispute with his employer during which he "tightened up" and felt he was about "to blow his top".

Four days after discharge from the Service, he married on borrowed money. After marriage he and his wife worked until he insisted that she stop because "a woman's place is in the home". Their three children were born in rapid succession. After the birth of their last child, his wife developed a condition which her doctor said would require surgery and prevent further pregnancies. The patient related that his own ministrations removed the cause for surgery. His wife was now well with the exception of being unable to sleep in the dark. One night, their light burned out and she woke up screaming.

A discussion of resources to help solve these financial and medical problems led to a referral to a veteran's agency for financial aid and the patient's decision to discuss his interviews with his wife before handling his medical problems.

In conference the physician stated that he thought the patient was a latent schizophrenic and recommended that the worker continue her present activity.

When seen on his twelfth hospital day, the patient again expressed concern over his family. This time a phone call revealed that his children were sick. As a result, he decided to request a pass. He recalled that last time he started for home, he turned back. He had borrowed enough money for a one-way trip and on his way, became nauseous, people were staring at him, so he returned to the hospital.

Later he was given a pass by the physician and his fare by the worker.

When he returned from the weekend pass, the patient expressed his satisfaction with home conditions. In addition he discussed the precipitating stress which brought on his hospitalization; he verbalized freely on his wife's people and not so freely on his own, and for the first time outwardly discussed his own symptoms. Finally, he expressed a wish to be discharged.

His arrival home caused his wife and children to improve, they were so happy to see him. A discussion of his social service interviews with his wife resulted in their decision to ask for help in planning their medical care. They were receiving money regularly

from the veterans agency. His wife learned that she and their son would not be ready for these operations until their health had improved. Consequently, the patient had been concerned over his ability to meet these expenses, himself, later on. The worker suggested that this was possible, but in the event that he had not saved the money he might want to know some possibilities. The patient replied by saying that he talked with the worker just a he talked with his wife; neither "lets me down".

Prior to this admission, after having given up his job, without the prospect of another, the patient did not have the courage to tell his wife. He called his physician, describing his "nerves", and, at the doctor's suggestion, entered the hospital; at that point he was able to tell his wife about the job. He added that perhaps if his application for a job had been accepted, he would not have "landed" in the hospital.

He described his mother-in-law as a wonderful woman who would lend him money to start a business any time he wished. He had the idea of becoming a barber under the G.I. Bill, and eventually establishing a business of his own. About his own family, however, he was not so optimistic. With difficulty, he related that his father often reminded him of the deprivations he suffered.

For the first time, he was able to discuss his symptoms. He did so as though the worker knew all about them, and they were accepted on that basis. He related that he did not awake frightened, perhaps because he was not worrying now. No that he was frightend of anyone--it wasjust that he wasnervous. As children, a brother and sister were that waytoo, only his sister was worse; she had to have the light on all the time.

Now that he was not worrying any more and he knew there were people to help him when he needed it, he expressed a desire to be discharged after the worker arranged the referral to the health agency. He felt that he would be less nervous at home looking for work, knowing the veteran's agency would provide for his family until he found a job.

In conference, they physician discussed the marked improvement he had observed in the patient since his home situation had improved. Although he felt the patient was still a sick man, he hadprobably achieved maximum hospital benefit. The doctor suggested, however, that the patient, himself, be included in the referral to the community agency.

Consequently after the referral which included out-patient therapy for the patient, he wasdischarged.

This case was referred for very tangible reasons with the added advantage of concerning a patient who was eager for case work services. Through handling his immediate problems first, the worker gave him the opportunity of relaxing and gaining trust and confidence in the worker. With the clarification of some of his problems, the worker interpreted to him the agencies in the community established to help people with his problems. Through a positive relationship, the patient was enabled to verbalize on the chain of events leading to his hospitalization and to discuss realistically his own symptoms. The worker sympathized with him over having such disturbing events happen about the same time and gave reassurance whenever possible; the worker supported his ego structure in his desire to prove himself a man, while at the same time encourageing him to accept for a brief time outside help for himself and his family. Case work activity had the final purpose of helping the physician arrive at some conclusions regarding the patient's psychiatric condition.

Patient E: illustrating failure of case work activity with the patient whose condition proved irreversible; illustrating case work activity as a diagnostic and prognostic aid.

The patient was a forty year old, separated veteran of World War II, admitted for the second time because of severe pain in both calves, recurrent edema of the legs, extreme tremulousness of six years' duration, and insomnia for the two weeks preceding this admission. He vaguely attributed his present illness to his Military Service, claiming repeated hospitalizations which could not be verified. He denied any drinking and stated that he ate well. He had had no consistent employment since before World War II when he was employed as a marine plumber.

His first admission was a year ago when he was hospitalized for

one month with neurodermatitis. Since then, he had been staying at his mother's home because of tremulousness and nervousness and was bed-ridden for the two weeks prior to this admission.

Physical examination revealed a man who was stooped with a sallow, pallid skin, "liver palms," an unsteady gait, and active tremulousness. The physical examination revealed an intermittent cough and a severe nutritional deficiency. The psychiatrist's initial impression was probable chronic alcoholism.

This case was referred to social service by the physician three days after the patient's admission for an interview with the patient's mother to confirm the diagnosis.

An interview with the patient's mother, an elderly feeble woman, confirmed the physician's suspicion. She expressed relief over her son's hospitalization because she knew where he was and had no fears that her house would be burned. She cried as she related his daily habit of drinking in a tavern, returning home to smoke several packages of cigarettes and then going to sleep withoug eating. Several months previously she supplied him with money to take a training course in a distant state. He returned a few days later drunk and without any money.

In relating details of the patient's marriage, his mother tried to be impartial. While in the Navy, after having left school against his parent's will, he met a girl whom he brought home, saying that she was pregnant and he wished to marry her. His parents arranged the marriage, gave them two rooms in their home, and a year later the patient was discharged from Service. The couple seemed willing to depend on his parents until it was suggested that they establish their own home which they did. They seemed contented for about a year, then started to quarrel and drink. Ten children were born, although the last two children are not the patient's. The mother proudly related that her son had always claimed these children to be his, nonetheless.

Regarding her own marriage, she stated that a few hours after hermarriage fifty years ago, herhusband left voluntarily to fight in the Boer War, returning a year later "on crutches". During his absence she had established a small business and was disappointed when on his return he was too restless to settle down. Accordingly, the family, including two daughters, moved to another continent where the patient was born.

The interview terminated with the mother expressing a wish to move in with a daughter, but being unable to do so because her son would not have a home. She said that she could not let him suffer because he had always been good to her.

In conference with the physician, the social service interview confirmed the diagnosis. The physician was interested in additional knowledge of the patient and relationship with his father as a basis for treatment. In addition the physician requested that the worker see the patient regarding discharge plans.

When interviewed, the patient was apprehensive, wary and verbalizd with difficulty. He was a pale, stooped man whose hands shook noticeably as he spoke. He discussed the severity of his symptoms which prevented him from accepting employment, his own attempts at rehabilitation, and compared the hospital with his previous institutional placements.

The worker expressed an interest in him and related that she had visited his mother. For five years he had been unable to work steadily because of his skin condition. He had tried a wide variety of jobs only to have an exacerbation of his symptoms. In addition a court record through marital troubles prevented him from securing other jobs. He could not pursue his own trade because it required the handling of substances irritating to his skin and he shook too much. Recently he failed in his attempt to take a training course because he could not stand the crowds and became "nervous". He felt the only kind of work he could accept was a job as a watchman. He had some friends, prominent in politics, looking for such work for him. He discussed his interest in leaving the hospital which he compared to "doing time" because he could not get a pass every night. It was very unlike the soldiers' home where he could leave every night. He conceded, however, that food and care in the hospital was good.

As the interview terminated, the patient requested that the worker advise his mother when she planned a visit to prevent her from becoming upset.

In the second interview with the patient's mother, she reiterated her joy at being able to relax since her son's hospitalization. She expressed a wish that her son would live elsewhere on his discharge. In addition, she told of the patient's relationship with his son and with his father. The patient's son was indifferent to his father's condition, being too busy to visit him at the hospital. The boy who was in the Army was "girl-crazy". When her son was drunk, he often reminded her that he took his first drink with his father. Although she reluctantly agreed that such might have been true, her husband, unlike her son, always took care of his family and never drank to excess.

The worker supported the mother in that the patient would be encouraged to accept employment which included board and room.

In conference, the physician and the worker concurred on a simple, non-demanding type of institutional employment for the patient. Since it wasfeared that court demands for the support of his children, now being supported by a public agency, would discourage the patient from employment, the worker planned to explore this possibility. The psychiatrist concluded that the patient's relationship with his father was inadequate since there was identification only through a drinking pattern. The patient was going to Occupational Therapy regularly and would be discharged as soon as his legs healed.

In the interim, the worker, contacted the public agency clarifying the patient's financial responsibility and secured a job possibility. The agency considered the patient a poor employment risk and would not expect any support from him until he had been steadily employed for one year. A job as watchman was obtained, which, although theoretically suitable, would probably not be acceptable to the patient on account of his general resistance to employment.

Four social service interviews were held with the patient over a period of one month. Each interview began with a verbalization of his symptoms. Although his ankles were symptom-free, he still complained of pain in his legs.

The worker's focus in the first tow interviews was directed at discharge planning. The patient reminisced about his former jobs of responsibility and security and as he talked his tremulousness decreased. This led to talk of jobs, friends obtained for him which, despite his efforts, led to the return of his symptoms. The employment possibility was discussed and finally rejected by the patient because he "could not come and go as he chose". The two remaining interviews concerned the patient's verbalization for the first time on his family and his drinking. He described his children as leaving home as soon as they started to work because of their mother. He described "sacrifices" he underwent for his children, his experiences in jail, and the reason for his drinking. With seemingly little affect, and in a veiled manner, he related that his wife falsely charged him with an unnatural assault on his daughter. He did not defend himself because his testimony would have uncovered information which would have resulted in his children being taken from their mother. On his return from service, although he was divorced from his wife, he remarried her on learning that she was illegitimately pregnant. Again he wished to protect his own children, caring little for his wife who had him jailed so often. When the worker expressed regrets over these unfortunate occurrences, he said that he did not mind. While in jail he learned to become a barber and also helped with electrical work. The worker did not show much interest in this assault on his dauthter because his purpose in relating this seemed based on his assumption that the worker knew it already. To discuss it now

would probably provoke too much hostility within the patient.

When the worker suggested that there were two sides to every story and wondered what his wife's side would be, he replied by saying that he supposed it would be "drink". This was the first time the patient admitted excessive drinking. He continued that he once had arthritis of the spine and drank a quart or two of rum each day for the pain. He later changed to beer when he started to lose his memory. Once doctors attributed his condition to alcohol, and to prove them wrong, he abstained for one year.

The interview closed with the patient deciding to make his own discharge plans.

In conference with the physician, it was decided that the patient could not benefit from case work. The physician had consulted the medical service and learned that the patient's physical symptoms had improved sufficiently to suggest his discharge.

The patient was discharged with a diagnosis of chronic anxiety state.

At the outset the referral process included a visit with the patient's mother to enable the physician to confirm his diagnosis. This accomplished, the referral process then consisted of work with the patient, himself, in discharge planning. Early in the interviews the patient proved unable to establish a relationship with the worker. She represented someone who was going to try to restore him to the community from which he wanted escape, therefore he resisted her interest from the beginning. Repeated interviews with the patient were of no value to him in gaining an appreciation of his real problems, and no satisfactory progress was made by the patient with the worker in formulating a plan of action. The chief value in case work activity beyond assistance in establishing a diagnosis, lay in achieving a realization of the limits in therapy for this chronic, alcoholic patient who would not relinquish his symptoms because it meant leaving the protective environment of the hospital.

Chapter IV

DISCUSSION

Every patient on the Neuropsychiatric Service is burdened with some degree of uncertainty, confusion, and anxiety. To counteract these burdens the worker establishes rapport "through a meeting of the minds exactly at the point of difficulty, and by a direct and confident approach".[1] Through this approach the situation becomes clarified and the patient's confusion is lessened.

Social work literature is in universal agreement on the kind of patient-worker relationship which is most conducive to successful case work, and on the importance of that relationship. It has been the author's experience to see the value of this relationship in the field of social work and also in the broad field of human relations. Gordon Hamilton described her approach to the person with a problem as an attitude of receptivity which frees the client to express himself and his feelings about his problem.[2]

The psychological approach of the worker which forms the basis of this positive patient-worker relationship embraces many elements through which the patient's confidence in the worker is established and maintained throughout treatment. This relationship is warm, natural and outgoing,

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[1]LeRoy M.A. Maeder, M.D., "Generic Aspects of the Intake Interview," The Family, 23:1, March, 1942, p. 15.

[2]Gordon Hamilton, "The Underlying Philosophy of Social Case Work," The Family, 22:5, July, 1941, p. 144.

usually involving some transference and identification whereby two human beings work together towards a common objective. In understanding the patient as a person and his problem as a maladjustment, thecase worker will, according to Dr. Maeder[3], elicit and define the difficulty, the problem, the nature and degree of the deviation of the person from his normal way of functioning and at the same time give the patient some inkling of her findings, thoughts and conclusions.

There is general agreement as a result of work in the field on the importance of the worker's ability to identify with the patient, to understand his need and to give him genuine acceptance. These factors are considered dynamic elements in social treatment. They involve the patient's ability to express himself freely and get release from pent-up emotions. In some cases, release is all that is possible, in other cases, the patient may be ready to use an intellectual approach and to something about him environment. Sometimes the patient may extend his verbalizations on his emotional maladjustments beyond the area of case work into the field of psychiatry. It is important for the worker to be alert to this situation and correct it.

The patient-worker relationship has many elements of the parent-child relationship. It is based on the warmth, acceptance, understanding and support which the mother gives to her child. The samedevelopment that is encuraged in the child, manifests itself in the patient-worker relationship. The mother's acivity is based chiefly on love and

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[3]LeRoy M.A. Maeder, M.D., "Diagnostic Criteria--The Concept of Normal and Abnormal," The Family, 22:6, October, 1941, p. 171.

intuition, however, whereas, the case worker's activity is based on a professional body of knowledge.

As with the child, the patient through the worker's continued support and understanding is enabled to gain increased self-confidence and courage to face the world outside inspite of his handicaps.

A relationship having attributes described in the literature and practiced in the field is also important in everyday living. The author has consciously used some of these theoretical concepts in social relationships with successful results. It has been a source of great satisfaction to stimulate friends to talk about themselves, (a task which always seems agreeable to them), and then to see their response to understanding, encouragement and emotional support. A source of deep pleasure has been the eagerness with which friends relate their life experiences. The author is reminded of a friend who said when she had not recalled an event he related: "I must have told you; I tell you almost everything."

Not to be overlooked in any discussion of case work activity is environmental manipulation. To properly evaluate the patient's environment, it is necessary to know realistically the strains which exist, the strains the patient thinks exist, and his attitudes towards these strains. Oftentimes what seems on the surface to be an overwhelming burden, may be to the person who bears it, something that he can accept with little difficulty. Other times a strain which in reality seems minimal may appear catastrophic to the person involved because of his emotionally disturbed state. It is therefore necessary for the worker to evaluate the patient's environmental disturbances as an aid in

case work diagnosis and treatment.

When environmental manipulation is indicated, it can serve many useful purposes. It may serve to eliminate or modify stress in the patient's life situation which may have a direct bearing on his illness; it is an aid in the establishment of the worker-patient relationship, and it is of vital importance in planning for the discharge of the patient to a favorable community atmosphere. The same psychological approach that is used with the patient is used with his relatives. A relationship of confidence is usually developed to stimulate them to effect a change or modification in the patient's environment. Through interpretation the relatives are helped to understand the patient and his illness, and their attitudes towards him. This often effects a greater cooperation on the part of the patient's family in his total treatment which in turn helps the patient at least maintain the level of health and emotional stability he has on discharge from the hospital. When the home situation is not amenable to change, it then devolves upon the case worker to evaluate the extent to which the patient can accept a separation from his incapacitating environment. She can then establish case work objectives accordingly. Through the technique of rendering some tangible service to the patient, or to his family, the patient develops a feeling of encouragement that someone understands his problems and is taking steps to alleviate them.

Chapter V

SUMMARY AND CONCLUSIONS

In this thesis the author has studied case work activity through an examination of five cases. As a background for this study a description of social service, as it was practices on the Neuropsychiatric Service in conjunction with psychiatry and the other services interested in the treatment of the veteran was seen. In addition, the function of the case workerwith particular emphasis on case work activity was outlined to provide an orientation to the case material which followed. The five cases were presented in summarized interviews followed by sumaries of the case work activity demonstrated in each case.

Case work activity was seen in this study with particular emphasis on the psychological approach of the workeras an aid in establishing a relationship to affect treatment. In each case a warm, understanding worker who would establish a meaningful relationship with the patients and/or their relatives was sought by the physicians. In work with all of the patients, close contact between the physician and the worker was maintained throughout hospitalization.

The process of referral was an ever-changing experience for the physicians and the worker. With increased understanding of each patient, new goals were established, previous goals were altered and sometimes, as in the case of Patient E, the goals became increasingly limited as more knowledge of the patient was gained.

The phychological approach used by the worker to establish a

relationship of confidence whereby treatment objectives could be established and maintained, involved varied aspects. At the outset in each relationship the worker attempted to help the patient and/or his relatives express feelings; the worker manifested an interest in the problems they presented, gave reassurance and also attempted to give emotional support, sometimes by playing a parental role, to help the patient increase his capacities. The worker's warm, accepting relationship was an attempt to provide an impetus for the patient to talk about those subjects, generally charged with emotion, which were preventing him from adjusting to his life situation. Results of this approach varied from the complete freedom of expression seen with Patient D to the suspicion and mistrust of Patient E.

Symptoms and their influence on life situations were subjects often brought up by the patient in discussions, sometimes as a device to prevent the worker from getting into the deeper areas of conflict, as with Patient E, other times as a frustrating barrier which seemed insurmountable, as with Patient A.

Reassurance was given as part of case work activity. Attempts were made at reassuring Patient A that his psychotic father would not escape again; that Patient C could met those "cultured" people if he joined the right clubs, and that Patient B's wife was going to get the best maternity care available. Whenever it was possible, the worker imparted her respect and approval of the patient's activity, a method of strengthning his ego. With Patient A, the worker reminded him that having his father committed was a wise step and that going out with his friends was a good plan. Patient C was a passive man

who was content to shrink back from his responsibilities and then hate himself for having done it. The worker tried to reenforce the positive aspects of his personality by encouraging him to resume some of those responsibilities. The worker also attempted to relieve guilt feelings. When Patients B and D expressed guilt over being hospitalized, the worker manipulated their home situations to relieve that guilt.

Constantly in the worker's mind was the hope that by modifying environmental strains, the patients would be enabled to act more effectively for themselves. Patient B's wife was given an opportunity to ventilate and thus clarify many of her attitudes towards her husband which provided an opportunity to correct some of these attitudes which seemed to be contributing to her husband's illness. Through the warm acceptance of the worker she was able to face earlier more painful life experiences.

In conclusion, when one considers case work activity with the psychoneurotic patient, one must be mindful of their poor developmental backgrounds and the chronicity of their problems. Thus will the progress in objectives which a positive relationship and other case work methods effect have greater meaning.

Approved,

Richard K. Conant, Dean

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